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CLINICAL LECTURE.

ATRESIA OF VAGINA; FEMORAL HERNIA OF BLADDER.

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ATRESIA of the vagina may be complete or incomplete. Kussmaul believed it to be due to an endometritis at the time of exfoliation of the vaginal epithelium. Clarke asserts that the vagina is developed from the lower parts of the ducts of Müller, and that inflammation in the vaginal fetal tissue may cause atresia before birth.

Henrotin affirmed that there was no embryologic explanation for atresia of the vagina, and regarded all cases as postnatal.

Traumatism and inflammatory processes of the vaginal mucosa complicating some of the diseases of childhood are the most potent factors in the production of this anomaly. Most of the cases reported have only consulted the physician after marriage because of inability to consummate the marital act. In other cases the atresia is discovered by the hand of the accoucheur. One case is reported in which copulation took place per urethra —the spermatozoa reaching the vagina behind the atresia through a urethro-vaginal fistula. The anomaly was discovered by the obstetrician.

In another class of cases the occlusion is absolute and menstrual fluid cannot escape, so that when the patient arrives at the age of puberty and begins to menstruate, blood accumulates in the vagina (hematocolpos), then backs up into the uterus (hematometra), and fially out into the fallopian tubes (hematosalpinx). It is a case of this sort that we wish to report:

Miss M., aged 19 years, consulted the writer on February 28th, 1907, and gave the following history: Had pneumonia at three months of age. Had a vaginal discharge at times between the ages of three and thirteen years. First complained of pain in back and side two years ago. The pain gradually increased in severity and was more intense every three or four weeks, confining the patient to her room. She had never menstruated.

On February 28th, 1907, the pain was so intense that the patient returned home after starting to work, and was confined to her bed for several days. During this attack she vomited frequently, pain being localized in left iliac region.

A digital examination of the vagina revealed a blind pouch one inch from the vaginal orifice. Bi-manual examination could not be made at this time because of the nervous, hyperesthetic state of the patient. On March 18th, 1907, under a general anesthetic (the patient having been prepared for both abdominal and vaginal work), a bi-manual examination revealed the presence of a fluctuating mass, extending from within two inches of the vaginal orifice to within one-half inch of the umbilicus, and filling the entire pelvis, iliac and hypogastric regions. Inspection showed bulging of the abdomen to be more prominent on the left side

Operation.—A metal catheter was passed into the bladder, and after emptying this viscus the catheter was used as a guide to locate and steady the urethra. The index finger of the right hand was passed into the rectum for a similar purpose

A large-sized trocar was then insinuated (between the urethra and rectum, since they were in very close apposition toward the uterine end of the atresia), and passed into the most dependent part of the hematolcolpos. On withdrawing the trocar, dark menstrual clots oozed through the canula. When the

oozing ceased the canula was withdrawn, and with a small pair of uterine dilators the canal made by the trocar was dilated until the index finger could be inserted; then the finger was used as a dilator, and the rectum and urethra were carefully dissected from that part of the vagina forming the neck of the sac. About four pints of coagulated menstrual fluid came away, and the remainder was washed out with normal salt solution through a return flow uterine irrigator.

The external os was patulous and the cervix was as large and soft as that of a full-term pregnant uterus. The mucous membrane was dissected loose at the neck of the sac for a sufficient distance to allow its being pulled forward so as to cover the raw surface representing the length of the atresia, and was then sutured to the edge of the circumference of the mucous membrane at the distal end of the atresia, thus covering the entire vaginal canal with mucous membrane. Strips of sterile gauze were carried to the posterior vaginal fornix for drainage.

The patient did well until March 24th, then symptoms of general peritonitis developed, and she was placed in the exaggerated Flower position, and continual enteroclysis of normal salt solution commenced. Every four hours she was given an ounce of panopepton in normal salt solution, per rectum. She was kept on this treatment until April 2d, when she passed a large quantity of pus per rectum, after which convalescence was rapid.

Patient menstruated on November 3d, 1907, the first time since the operation. Every two weeks a small bivalve speculum is passed to maintain the patency of the vagina, the glass dilators being intolerable. She has gained twenty-five pounds in weight, and is robust.

HERNIA OF THE BLADDER.

Hernia of the bladder may be inguinal, femoral; through the pelvic floor, or linea alba.

Brunner analyzed 180 cases occurring up to 1889. Of these 138 were inguinal 29 femoral and 14 the other varieties. The para-peritoneal and extra-peritoneal are the most common varieties, the intra-peritoneal being rare. Traction on the bladder by the descending hernial sac, through that part of the peritoneum covering the bladder may cause either the variety known as para-peritoneal or intra-peritoneal, but when the bladder alone is herniated the mechanism of production is different. Frequent distention of the viscus from obstruction to its outlet, if long continued, may cause a diverticulum. If the hernial orifice be weak, the intra-abdominal tension caused by labor pains, for example, could easily force such a diverticulum with its prevesical fat into one of them. Such we believe was the mechanism of production of the case herein reported. Cases of operative cystocele have been described as being due to traction on the sac while it was being dissected free and ligated.

Report of Case.—Mrs. K. noticed a lump in right groin seventeen years ago, about six months after the birth of her youngest child. The lump was about the size of a small hickorynut at first. It gradually increased in size, but would almost disappear at times. During the whole seventeen years the patient urinated frequently, passing small quantities of urine at a time, and emptying the bladder did not relieve the desire to urinate.

On August 17th, 1907, she had severe abdominal pain and vomited several times. The pain continued for three hours. August 23d, 1907, pain returned, and was accompanied by persistent vomiting. She was given one-fourth grain morphine subcutaneously, and her physician made three attempts to reduce the hernia by taxis, but failed. At 10 a. m., August 24th, 1907, the patient reached the operating-table, having traveled 150 miles, and having vomited persistently all the way —in very bad condition.

Operation.—An incision three inches long, one-half inch below and parallel with Poupart's ligament, was made. Before reaching the sac we dissected through an unusually large amount of fat. The sac was as large as a small orange, and its wall was very thick. The neck of the sac was very small.

The femoral ring was incised on the inner side, dividing Gimbernat's ligament. We then opened the sac, and found that its cavity was obliterated by an agglutination of the inner walls. A steel sound was then passed into the bladder per urethra till its end could be felt just below the constriction of the neck. No opening could be found connecting the diverticulum with the bladder. For this reason we opened the space of Retzius in the median line, and demonstrated conclusively that the diverticulum was from the anterior and lateral surfaces of the bladder in front of the peritoneum.

The wound in the diverticulum was then closed with a running Lembert suture (silk), and the diverticulum returned to the abdominal cavity. Both the abdominal and femoral wounds healed by first intention.

The patient had a mild cystitis, which disappeared during the second week of convalescence.

Cases of femoral hernia of the bladder alone are rare, the inguinal variety being four times as frequent. Cheesman collected 93 cases in which the bladder was wounded,

with a mortality of 26%. In the 180 cases collected by Brunner the diagnosis was made before operation in 13. In the same series the bladder was injured in one-third of the cases.

SUMMARY.

1. When a virgin gives a history of amenorrhea, and describes symptoms which ordinarily accompany the menstrual period, the physician is justifiable in subjecting her to a bi-manual examination under anesthesia.

2. In operations for the radical cure of hernia, or for strangulated hernia, a sterile and urethral sound should always be ready for exploration and identification of the bladder.

3. If after a hernial sac has been opened and its contents returned to the abdomen a second sac appears within the first, or to the inner side of it, it is not to be opened until a sound has been passed into the bladder and it has been positively identified.

4. Any hernial sac which is unusually thick and covered by an unusual amount of fat should warn the operator of the possibility of a hernia of the bladder.

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LEPERS PLEAD FOR HEALER.—A petition bearing the signatures of 525 lepers has been sent to the Territorial Board of Health of Hawaii from the leper settlement, Molokai, asking that J. Lor Wallach, Honolulu, who is said to have been convicted of practicing medicine without a license, be allowed to treat them with a remedy which he claims to have for leprosy. The board is said to have evidence that Wallach is a fraud, but among laymen and native Hawaiians he is said to have an extraordinary following.

SMALLPOX IN VIENNA.—It is reported that fifty-five cases of smallpox have occurred in Vienna within the past eight days. This naturally has caused some alarm as not more than twenty-two cases of this disease have been reported in this city during the past ten years. Of the fifty-five patients most of them are children and the majority have not been vaccinated. The epidemic is due to the immigration of large numbers of Russian fugitives, but most stringent measures have been adopted by the authorities to stop the spread of the disease.

LEADING ARTICLES

THE CIRCULATORY SYSTEM.*

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THE circulation of the blood is of fundamental importance to the body. It is through the circulatory system that food materials are carried to the tissue cells for nutrition, and their waste products removed for excretion. A constant and sufficient supply of oxygen, various salts and nutrient materials to the cells of the body as well as a constant removal of their waste products are necessary requisites for a normal course of life. These functions of the body, through the medium of the blood, are carried on through a system of tubes, arteries, capillaries and veins and a central propelling organ, the heart.

With normal blood, a disordered condition of the circulatory system may have its origin either in the pump which propels the blood or in the tubes through which it flows.

It is said that the heart is the best motor known to man. It performs equally well the small amount of work necessary when a man is at complete rest and the large amount necessitated by great exertion. It possesses extreme adaptability, and what is of greater importance the adaptability of a normal heart occurs precisely at the time it is most needed. A normal heart is, therefore, peculiarly adapted to propel a certain amount of blood into the arterial system at short, regular intervals, by the contraction of the muscular walls of the left ventricle, slowing and increasing the rapidity of these ventricular contractions, as well as decreasing or increasing their force as the needs of the system may require under conditions of rest or exercise.

Normally when each ventricular contraction of the heart expells blood into the large arteries it forces this fluid into a system of distensible, elastic tubes. Distensibility, elasticity, and contractility are, therefore, normal properties of the large arterial tubes. When by the expulsive forces of a normal ventricular contraction blood is forced into the large arteries, they are, therefore, filled and distended, and immediately following this distension comes the contraction of these large blood vessels which drives the blood into the smaller blood vessel throughout the body.

Normally we must remember that the heart does not force the blood directly to the end of the toes and fingers by the force of its ventricular contraction, and not even to the

*Read before the Tri-State Medical Society at Moberly, Mo., September 18, 1907.

ultimate distribution of any of the minute arterial tubes of the body, for even the coronary arteries which supply the heart muscle itself are filled by the recoil of the aorta on the volume of blood it contains. The real work of the heart is therefore not spent in driving the blood through the body at each ventricular contraction, but simply in distending the rubber-like elastic large arteries, and the stronger the ventricular contractions, providing the peripheral resistance to the blood is normal, the greater will be the stretching or distension of these large arterial tubes, and therefore the stronger will be their recoil or contraction upon their contents, and the more forcibly will the blood be driven through the arterioles and capillaries of the body. The larger the artery the more does the elastic element predominate. In the arterioles, or smaller blood vessels the muscular power predominates over the elastic power, and is relatively to the size of the vessel, much better developed.

The large arteries by their elasticity and contractility help to convert the intermittent force of the heart into a continuous force or a continuous blood pressure.

In the circulatory functions of the body so much depends upon a normal degree of distensibility and contractility of the large arteries that if these properties are lacking the circulatory functions are crippled, notwithstanding the fact that the heart may be in a normal condition and perform its work well. We can thus clearly see that the distension of the large arteries is caused by the pressure of the blood which is forced into them at each ventricular contraction, and that the contraction of the large blood vessels is simply the recoil of these large rubber-like, elastic distensible tubes upon their contents.

The dilatation and contraction of the smaller arteries, the arterioles, we find, however to be of a different nature, being less mechanical and more physiological in their action, and not a contraction due to the recoils of distended elastic tubes, but a contraction from the action of circular muscular fibers which surround the small arterial tubes, and whose action are controlled by the vasomotor system of nerves. The power of the smaller blood vessels to contract and expand under the influence of the vasomotor system of nerves is a very important part of the construction of the circulatory system, as by this means the blood supply to the different parts, or different organs of the body, is regulated as its needs demand.

For instance, after a meal we will find the blood vessels of the stomach active, dilated and full of blood to aid in digestion. When one goes to sleep the blood vessels in the brain contract and the brain is poorly supplied with blood. When one awakes the blood vessels of the brain dilate again and keep the brain properly nourished while at work. When a part of the body is injured the blood vessels around the injured part immediately dilate and the part becomes red and swollen, for a protective and physiological purpose to guard against infection and to furnish abundant material for repair. However, arterial dilatation and arterial contraction in various pathological conditions may pass beyond their normal limits. Widespread dilatation of the small blood vessels may lead to a serious fall of arterial pressure, for the total quantity of the blood in the body is insufficient to fill the blood vessels properly if they are all widely dilated. Such arterial dilatation may result from a widspread loss of arterial tonus. Thus if the splanchnic vessels of the abdomen lose their tone and become widely dilated they become filled with blood, and the arteries to the other parts of the body, especially the skin and muscles and the brain are left comparatively empty. Such a patient becomes weak and pale; the arterial and venous pressure fall, and the heart receives an insufficient supply of blood. The pulse becomes soft, weak and rapid, and syncope or unconsciousness supervenes. Such a case is practically bled to death in his own abdominal vessels, and life may last only a few hours, or even on a few minutes. If other arteries in addition to the splanchnics are dilated the symptoms are intensified, yet the condition of the splanchnic vessels are of paramount importance on account of their great capacity. Such conditions of extreme loss of arterial tonus is due to an extensive vasomotor paralysis, and is frequently found in shock from injuries, or after operations, or the so-called collapse that sometimes occurs in infectious diseases, or by toxic doses of chloral or alcohol. Even in cases of peritonitis the cause of death is often due to toxic paralysis of the vasomotor centers, with widespread loss of arterial tonus, rather than to cardic weakness as we have all found in many cases in our clinical bedside examinations, when we see such patients dying with a weak rapid heart with lack of sufficient arterial tension to keep up the processes of life.

In cases of death from vasomotor paralysis the large arteries are so empty that the volume of blood expelled into them at each ventricular contraction does not distend them, and therefore the secondary contractile function of the large arteries which forces the blood throughout the peripheral circulatory system does not take place.

When such a patient is dying because of vasomotor paralysis with very weak pulse with no arterial tension, with the large blood vessels comparatively empty, with most all of the blood in the small vessels and capillaries. We can readily see how such so-called heart remedies as nitroglycerine and other vasodilators can do great harm in still further increasing the cause of the failure of the circulation by producing a still greater dilatation of the capillaries.

The circulation of the blood is therefore dependent upon two important factors, the cardio-motive force behind and the peripheral resistance in front. No matter how strong the muscular walls of the heart may be if the peripheral resistance to the flow of blood is lacking the patient may die from failure of the circulation due to the fact that there is not sufficient blood pressure in the large arteries to distend them at each ventricular contraction of the heart, and consequently there is no recoil of these large blood vessels on their contents to drive the blood through the peripheral circulation. The peripheral resistance of the blood is due in some degree to the friction of the blood in the arteries and capillaries, to a small degree to the viscosity or the consistence of the blood, but most largely to the small diameter of the minute blood vessels and capillaries. The smaller the lumen of the minute blood vessels, or the more they are contracted the greater the peripheral resistance to the blood current. The diameter of the small blood vessels may be temporarily increased or diminished by a contraction or relaxation of the walls of these vessels by the vasomotor nerves, or permanently diminished by a thickening of their coats which impinge upon the lumen of these small vascular channels. We can thus readily see that the smaller the caliber of the peripheral arteries the greater will be the resistance to the peripheral circulation, and consequently the greater will be the pressure in the large arteries also. This brings to our attention the interesting subject of arterial tension, which is simply the intravascular pressure, or the blood pressure within the arteries, and which is dependent upon the force with which the blood is driven into the arteries by the cardiac contractions of the left ventricle, and the obstruction, or rather the resistance to the outflow of blood in the capillaries. Arerial tension is therefore raised by increasing the cardio-motive force behind and the capillary resistance in front. We find all degrees of arterial tension in examining our various patients, from that of an almost imperceptible pulse to that of a full-bounding, non-compressible arterial pulsation.

Where a heart is failing from pumping blood up against a high arterial pressure we must not let the signs of cadiac exhausation, cardiac failure, or cardiac dilatation divert our attention from the marked peripheral obstruction, or the resistance offered to the circulation from contraction of the capillaries, and jump to the conclusion that the failure of the heart is due primarily to an actual lack of normal strength of the heart muscle, when in reality its failure is due to exhaustion from being compelled to force blood into the large arteries against a high arterial pressure. To attempt to relieve a heart under conditions of this kind harm can be done by giving remedies to increase the force of the ventricular contraction without relieving the peripheral resistance. Proper relief in such cases can only be obtained by dilating the peripheral blood vessels, and thus reducing the blood pressure by facilitating the flow of blood from the large blood vessels.

This condition of heart failure resulting from cardiac exhaustion from the pumping of blood up against a high arterial pressure is simply the reverse of the condition which causes failure of the circulation from a widespread vasomotor paralysis with general vascular relaxation, and requires widely different treatment.

Permanent, abnormally increased arterial tension in almost all cases, is due to that diseased condition of the arterial common known as arterio-sclerosia. In this disease of the arteries the coats of the blood vessels are thickened and hardened, their elasticity and contractility lessened and their lumen or caliber diminished. If this condition is general the blood pressure becomes high and frequently causes rupture of some weakened blood vessel. An arteriosclerosis of the small blood vessels of the kidney leads to a chirrotic kidney and death from chronic interstitial nephritis. An arteriosclerosis of the arteries of the brain may lead to softening of the brain, or death of apoplexy. An arteriosclerosis of the blood vessels supplying the muscular structure of the heart may lead to chronic fibroid myocarditis, and finally death to weakness of the heart muscles as a result of the fibroid changes. An arteriosclerosis of the coronary arteries may cause violent attacks of angina pectoris and weakness of the heart and death from lack of proper nutrition to the heart muscle. Death in these attacks commonly ascribed to neuralgia of the heart.

In general arteriosclerosis the condition can be diagnosed by inspection, palpation, auscultation and various clinical symptoms in general. In all marked cases the superficial vessels are elongated, tortuous and pulsate

visibly. The arteries feel hard to the touch and resist compression. The arterial tension is high, severe arotic sound accentuated, the pulse strong, non-compressible and the artery frequently feels hard like a cord under your finger. Hypertrophy of the heart occurs early in the course of the sclerosis of the arteries on account of the great peripheral resistance to the circulation. Dizziness, roaring noises in ears, the frequent passage of large quantities of pale colored urine, as a result of the high blood pressure, pain or sense of fullness in region of heart from strain of heart muscle due to high pressure in arteries, cramps, coldness of the limbs, are all important symptoms of arteriosclerosis. Some cases of gangrene are due to obliteration of the blood vessels by arteriosclerosis of the vessels supplying the part with blood. The most important determining causes of this form of arterial disease are chronic intestinal intoxication, rheumatic and gouty diathesis, syphilis, lead and alcoholic poisoning, excessive straining and laborious occupations. Certain arteries of the body are more prone to this particular morbid process than others, and the predilection for those degenerative changes in the arteries of special organs of the body seem to be determined to some extent also by the agent producing these degenerative arterial changes. For instance, gout and Bright's disease are associated with changes in the walls of the small arteries and since the morbid matter in the blood must be eliminated this organ especially suffers.

Syphilis may attack any of the arteries of the body, but it has a special predilection for the vessels at the base of the brain. Chronic alcoholism subsequently produces degenerative changes in the liver. Mechanical strain due to laborious occupations is felt more by the aorta and large blood vessels.

The importance of a knowledge of the physiological functions, pathological disturbances, and diseased conditions of the arterial system can in a great measure be realized when we note the numerous morbid conditions of the body which may arise from disease of the blood vessels.

Chronic interstitial nephritis, cirrhosis of the liver, cerebral hemorrhage, angina pectoris, myocardial degenerations, gangrene of the extremities, all the valvular affections of the heart due to fibroid changes in the valves, insufficiencies and obstructions, numerous neurotic conditions and many other ailments of the body are the result of disease of the arterial system.

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WHAT YOU CANNOT DO WITH PURGATIVES.*

EDWIN WALKER, M. D.

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IN spite of the rigid criticism and enquiry of our age, there is still in medical literature much which is untrue. An incorrect observation or an immature conclusion by some recognized authority is quoted for years, perhaps for generations, without question. The medical profession is swayed by fads and fancies, as well as the laity, and possibly in no less degree.

Brown-Sequard, like many other brilliant but erratic teachers led the profession astray for almost half a century by his views on reflex irritation as a cause of disease. The proprietary medicine man has reaped his harvest through the credulity of the doctor. Bare assertions of the venders were enough in most cases, but there has been no difficulty in obtaining the most glowing tributes from reputable physicians to boom their wares when interest waned.

It behooves us, therefore, to carefully analyze and sift everything and accept only what rests on scientific demonstration.

The use of purgatives has been so general, from the beginning of medical knowledge, one would expect to find distinct and clear exposition of their mode of action, and definite and reliable indications for the use and with this their contraindication and dangers.

A brief review of the subject in recent works on therapeutics will convince anyone that our knowledge is far from satisfactory, and that but little of value has been added to our knowledge in the past decade. If you seek to learn in what manner they act, you will find that about the only point on which all are agreed is that they are irritant, and when excesssively used produce inflammation. The resemblance in action of purgatives and infections has been pointed out (Walsh). Roos found he could produce purgation by feeding live cultures of the colon bacillus, while dead ones had no such effect.

On the other hand, A. Schmitt, Strasberger, and others have found that constipated stools contain fewer germs, and undergo putrefaction slowly, even in an incubator.

Clinical observation confirms this. Purgatives produce liquefaction of feces, by a fluid which cannot be differentiated from an inflammatory exudate, increased formation of gas and griping. In what does this pic-

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ture differ from enteritis due to infection? There is most probably increase in germ life in both.

The purgatives most frequently prescribed are calomel, salines and castor oil.

In spite of its general use and repeated experiments on animals, the method and nature of the action of calomel on the human system are in dispute. It is claimed that its action is due to its conversion into the bichloride, and this is denied by the best of authorities. Good authorities teach that it increases the flow of bile, while those equally as distinguished tell us that it diminishes it. Whether it acts on the liver cells or not is unknown. That it does powerfully affect the human system and in large doses is a violent poison is admitted by all. It does increase bacterial growth in the intestine, as its excessive use will cause enteritis.

Is this, then, a drug to be given as a routine? Should it not be withheld except when indications are clear? Should not its contraindications be impressed emphatically on every physician?

In regard to the action of salines we are equally uncertain. Their action by osmosis or by diminishing the absorption is hardly tenable. The result of experiments on animals, as well as clinical evidence, seems to discredit this view. On the other hand, the increase of albuminous exudate and gas, with the well-known irritating qualities of strong solutions, render it much more probable that they also act as irritants and increase germ activity in the intestines, and, if used excessively, produce inflammation.

They are doubtless useful in some conditions, although I am not quite sure that much can be accomplished by them that cannot be as well or better done by free use of water. There is no doubt at least that they do better when well diluted, and possibly still better if left out entirely.

Then comes castor oil. It probably is one of the least harmful of purgatives, but it does not act by its soothing, oily properties, or mechancally. Its acton is due to ricinoleic acid, and the action of this ingredient is compared to the active principle of croton oil. Castor oil is an irritant of the same class as croton oil, only milder; its frequent use, if given in over-doses, will cause enteritis.

I can hear you say, "Are we expected to believe castor oil, that has stood the test of a century, is to be classed as a dangerous remedy?" I would not go too far nor do I deny that cascara, rhubarb and perhaps other laxatives do have a place in our armamentarium. It would be a bold man, in view of their general use to deny this; but I do claim that they are much over-used. This is not new at all since warnings against the abuse of purgatives have been often repeated for many years.

I do claim, however, that, notwithstanding repeated warnings, both physicians and surgeons use purgatives in a routine, perfunctory way, very much in excess of what they should. They not only exhibit them when they do no good, but often injure their patient. Do not most patients who consults a medical man get a purgative as the first prescription? And it is a notorious fact that practically all surgeons give a cathartic as the first step toward a preparation for an operation of any kind, be it for ovarian tumor or an ingrowing toe-nail. About all the advance we have made in this line is the eliminating of the drastic drug. I know of no way to express what the extent of this abuse of these drugs is. If I would express them in figures, a guess only, I would say that somewhere between five hundred and one thousand doses were given where one was really needed. A little startling, I admit, but, soberly, I do not think it far wrong.

I do not pretend, from my limited knowledge, to be able to give definite indications and contraindications for the exhibition of purgatives; that will require careful clinical and experimental study to do it with any accuracy. I can, however, point out a few things which cannot be done by purgatives.

The medical man is in error more frequently in the use of laxatives for chronic constipation and obstruction of the bowels, either acute or chronic. Before discussing these, I want to protest against the routine use of cathartics in acute cases, which we so often assume are due to an auto-intoxication, and that is a poisoning from the intestinal canal, a position far from tenable. Boas says: "The importance of intestinal auto-intoxication as an etiological factor of disease is still in doubt."

These toxins are generally far out of reach of a laxative. I am well aware that I am on dangerous ground, because we know so little about auto-intoxication. This being the case, is it not better to be careful in the use of drugs whose actions we know little of, in diseases of which we know less (Holmes)? In every case ask yourself what are you to expect. Is the dose indicated? If in doubt, do not give it.

No one has seriously claimed that purgatives or laxatives cure constipation. On the contrary, practically all those best able to speak say that they do harm, and their habitual use is the most potent cause of constipation. Spastic constipation is often caused, and always aggravated, by them.

We should try to discover the cause, and we will find most of them will be due to carelessness; next, errors of diet; then a small portion to a mechanical difficulty which should be overcome surgically, and about the same proportion to what we call atony, because we do not know anything about it, and in those few our ignorance compels us to give a laxative.

If, again, I may be allowed to put my guess into figures, I would say (and this is based on the record of about three hundred cases in which this point has been noted) that 98 per cent would come under the first and second headings; 1 per cent under the third, and 1 per cent under the last In the work of a general practitioner, the proportion of the last two will, I believe, be still smaller.

In acute ileus and intussusception purgatives are potent for evil, and, worst of all, the time for successful operation is often allowed to pass while waiting for the effects of drugs. In spite of all that has been said, such neglect is still far from uncommon, as every surgeon will testify. Purgatives are relied on in chronic obstruction very often until the lesion has occluded the bowel, and the patient's condition is such that operation is hazardous before the surgeon is consulted. These chronic obstructions are often due to cancer, it is true, and little hope can be held out. Still, early surgical interference would save some of them, and, what is more important, a proportion of the malignant disease is engrafted on benign lesions, and an early removal would result in complete recovery. I recently saw a patient with cancer of the sigmoid, with metastases to an extent that radical removal was impossible, who had had distinct symptoms of partial obstruction for fifteen years, during which time he was treated with purgatives by a number of physicians, none of whom intimated that anything else could be done for his relief. It is highly improbable that this disease was malignant for so many years.

The time has come when on the general practitioner, and not on the surgeon, will rest the blame for the unfavorable results in these bad cases.

The surgeon, in spite of his boasted medical nihilism, is not behind his medical brother in the thoughtless misuse of purgative drugs. I have yet to find a hospital in which it is not the practice to give to every patient who is to undergo any kind of an operation a purgative, if time will permit, and in a large majority they are used afterward; the practice varying from giving a dose just before the operation and continuing immediately after with salines, until the bowels move, preferably in the first twelve to twenty-four hours (Byford) to several days after.

If we can judge by works and articles on surgery, it must be a very small percentage who escape a cathartic both before and after operation. If the operation is not on the intestinal canal, why should we give it? And if it is on the prima via, what good does it do?

It goes without saying that a large proportion of cases who come to operation have not trouble with their stomach or bowels. Most of the directions on this subject are vague, and do not rest on fact. We are told to "unload the bowels." If there is loading of the bowel, it is in the colon. The small intestine has always fluid contents, and its peristalsis is most as constant and regular as the rhythm of the heart. Stasis in the stomach and small intestine is due, with only the rarest exceptions, to mechanical obstruction, for which drugs are useless. It took us ten years or more to get away from the practice of trying to purge out an appendiceal abscess. Fecal impaction in the colon is not common, and when it does occur, purgatives are poor remedies, and a single purge does not remove it; on the contrary, it adds fluid and more germs, which make the development of toxins more certain.

I think a moment's reflection will convince most of you that for operations other than those on the digestive tract an enema is better and more rational, whatever the condition may be. Even this is often superfluous, but patients are more comfortable to have the lower bowel empty, and we do not have to disturb them so soon afterward.

How is it about operations on the intestine? If the patient is long enough under observation to have a purgative, say twenty-four hours, his condition will be better and he will surely feel better if he is fed on a light, digestible diet, and allow his bowel to empty itself; if it does not, an enema will clear the rectum and sigmoid. If impaction of feces in the colon exists, several days at least will be necessary to remove it, and should be taken if the condition will permit.

As pointed out above, these drugs act as irritants; they increase the fluid in the alimentary canal, they increase the growth of bacteria and render them more virulent, and as a consequence increase the formation of gas. They weaken a patient, and bring him to operation at least more uncomfortable than he would have been without them. Of these reason, the stimulant given to germ life is most important, and with it we irritate the mucous lining of the bowels, making it less resistant.

Are we not doing with the intestines exactly what we formerly did with the skin. We

would scrub it, disinfect it, until normal resistance was diminished or destroyed. Our results have been better since more rational method were adopted. Why not do the same with the alimentary canal? Let nature alone, unless the evidence is clear she cannot do her part.

After the operation the rule should be the same; only give laxatives when clearly indicated. There is no good evidence that they have any power to limit infection if it has taken place; in fact, it is debatable if its possibilities for harm are not far greater.

If no complications exists, they are rarely required. The bowels will move spontaneously as soon as food in sufficient amount is taken. In an article on the abuse of purgatives (American Journal of Obstetrics, Vol. liv, No. 6) I mentioned the fact that impaction of the rectum was troublesome, but not a serious complication, in some cases. This can usually be remedied by getting the patient out earlier, but if this does not suffice an enema will be of service.

I have operated on nearly one thousand patients for a variety of diseases, a large portion abdominal, without the "usual purge" before, and of these not over 5 per cent had one after the operation. I am sure my results have been as good, and I think better, than when the giving of a purgative was a routine. The patients have been more comfortable, and the most marked advantage is that they have much less tympany. I cannot say the vomiting is less, but the convalescence is more comfortable, and fully as rapid as before.

In conclusion, I want to state that I do not deny that purgatives hold an important place in our armamentarium, and we could not do without them. I protest, however, against their routine use, for they are powerful for evil as well as good. I do not pretend to give final conclusions on so great a question, but think it is high time we were making a definite study of the indications and contra-indications of purgative medicines. They are not curative; at best, they can only give temporary relief, and when we have to repeat them it is good evidence that there is some underlying disease we have not reached. This may be almost anything but very frequently is an organic lesion such as tuberculosis cholelithiasis, nephritis or the like. In fact in the early stages of almost all serious diseases patients are injured and much valuable time is lost by a course of purgatives which most of them are put through. Their routine use in medical practice is indefensible; in surgical practice is absurd.

EDUCATION OF PHYSICIANS AND THE PUBLIC REGARDING INSANITY.*

FRANK PARSONS NORBURY, A. M., M. D.

JACKSONVILLE, ILL.

In the evolution of society one of the foremost problems which early confounded philanthropists and other social workers was the care of the insane. The medieval ideas with their mysticism, demoniacal possessions and a host of other gross superstitions surrounding the insane were first to be met and overcome. And as nothing in the way of medical thought existed whereby an attempt could be made to bring order out of this chaos it remained for some one imbued with the true spirit of scientific inquiry as well as philanthropic forethought to undertake this seemingly insurmountable problem. We know that when great problems are to be solved and great emergencies to be met there is always some one called providentially to answer the emergency and so it was here in the person of Pinel, of France, who with practical knowledge, courage and foresight and "happily for the insane world," created the revolution in the methods of treating a neglected and misunderstood disease, the effects of which were as remarkable as the contemporary French revolution in the government of sane people. When we think that just a little over a century ago this great man brought about this revolution and laid the foundation for our modern ideas of the care and treatment of the insane, we must place him among the foremost in the temple of the world's famous physicians.

The humane instincts, the noble and courageous work which prompted and crowned the efforts of Pinel, soon had their effects in creating other similar experiments, based upon the same noble inspiration, and as a result Tuke, in England, founded the York Retreat, from which eventuated the great movement in England, of awakening into the full light of civilization, the all-pervading truth, which today is recognized in all civilized countries, "that the unsound mind, like the unsound body, can only be regarded as an instance of disordered function; and that, however grave the disorder, the functions are still there, and may be roused into more or less healthy activity by exactly the same physiological stimuli and motives as are available in health." We can imagine with what zeal and earnest endeavor these early workers proceeded to educate, first of the physicians, and next the populace, regarding the needs of the insane. It is no wonder that

*President's Address, delivered before the Illinois Conference of Charities, Twelfth Annual Meeting in Jackson ville, October 9, 1907.

the clinical study of mental diseases was slow to be recognized; for it is an obvious fact that educational problems which are epoch-marking in their solution, require in order to become established, time, endless patience, and persistent endeavor. We must remember that there were social, political and religious influences then, as now, perhaps more intense and vituperative than today, but existing in a social atmosphere not so philanthropically disposed as in this, the twentieth, century. These influences conspired to hold in check clinical inquiry, and Pinel then, as frequently is the fact with superintendents of today, had first to get permission from the political powers that existed before he could even take a step toward advancing the cause of a single insane patient.

I will not burden you with the history of this revolution further than to say it has been slowly but steadily a movement characterized by developing scientific knowledge and broad humanitarian spirit. As we note the progress of the study of insanity purely along educational lines we find that it has closely followed the divisions which Janet gives in the study of hysteria,*viz.: first, a period of anecdotal recital; second, the clinical period marking the latter part of the nineteenth century, and the third, which is quite contemporary, the psychological, now prominently led by the German school of which Kraepelin is the chief exponent This evolution in its modern conception shows that there is no department of medicine in which the investigator needs to be more in intimate touch with the advances of modern science than in the study of mental cases. It further and emphatically endorses Bain's dictum,† "that a subject should not be presented to the pupil until all the preparatory subjects have been mastered." And when we consider of what these preparatory subjects should consist and the methods of their study and investigation we will find that they are the biological sciences and must be pursued with the same methods, the same diligence and exactness as characterize success in all scientific studies.

This is true, however, of all real educational progress, and to attain the ultimate aim and purpose of education, which James Mill says "is to render the individual as much as possible an instrument of happiness, first, to himself and next to other beings," we must attack the problems before us with these noble ends in view. Our greatest problems regarding the insane today are educational and they involve not only the needs of the insane themselves but the duties which the state and the public should discharge toward them and to the hundreds living and unborn who are to be their successors. Let us not forget that we have the insane with us always. We have had since history began and we shall have so long as man shall inhabit the earth Yes even if today all insanity were blotted off the face of the earth ere tomorrow's sun went down new cases would appear because man through the very constant laws of evolution and dissolution is subjected to the biological law of the survival of the fittest, and insanity is one of the channels through which this law works.

To meet these educational problems, we have two avenues to consider through which we hope to reach the ultimate aim of our purpose: First, by extending the clinical knowledge of insanity through the improved education of the medical profession, and, second, through popularizing our present knowledge of insanity, so that it may reach the public and be understood and appreciated by the people. Education is a public safeguard, and it is the duty of the medical profession to provide, through its channels, all possible knowledge to fortify against the inroads of mental disease. Medicine has, through its brilliant research work, in the study of infectious diseases, added years to the public health, saved thousands of people from premature death and extended the commerce of the world beyond computation. Medicine today, in other avenues of research, is adding to the peace, comfort and welfare of the people, notably in the study of diseases of metabolism(nutritional diseases); in this line of inquiry I believe we see a future in solving many of the mysteries of mental diseases here tofore misinterpreted and consequently ilogically treated. The recent work of Bruce, of Robertson and others sustains me in this hope. With the results thus attained and promised I further believe, perhaps I am an idealist and hope for too much, but I do believe the people stand ready and willing to have presented to them in practical form the knowledge of insanity which exists today and they will cooperate in solving the problems with this knowledge, just as they have in solving the problems of tuberculosis, yellow fever, malaria and small-pox. They await for the medical profession to inform them, and it is, therefore, incumbent upon this profession to qualify themselves in order to teach the people.

The trouble in the past and even now in our schools in the education of physicians regarding insanity has been and is the want of clinical opportunities in the medical

*Harvard Lectures, 1906.
†Education as a Science, p. 8.

schools, and save for a few of the larger schools situated in cities, where access could be had to detention hospitals, it was, and really is, now the rarest thing for a clinical lecture to be delivered on a mental case. Consequently the average graduate of the past never came in contact with a case of insanity, knew little of even the principles of insanity, for usually only a few lectures were delivered and they in their didactic dryness seldom appealed to the real wants of the students. In a great measure this criticism still exists for marks in mental diseases in many of the schools are not among the necessary credits for graduation.

Think of it, this department of clinical medicine which requires in its practice more real all-round knowledge of man and his diseases than any other is shelved for the want of opportunities to present its needs. No wonder physicians are uninstructed; no wonder the anecdotal knowledge is the only knowledge which the average physician in general practice possesses of mental diseases. No wonder the public knowledge of mental diseases is the remnant of "Bedlam" as displayed in the lay press, both in its columns and its cartoons. No wonder a morbid curiosity is created when superficial generalizations go for scientific deductions, and haphazard diagnoses and useless statistics choke real intellectual and collective investigation, all for the want of real opportunities for study and inquiry.

Fortunately, there is a dawn of a better day for clinical psychiatry, for while certain schools and hospitals have long given lectures, others have not, and only recently, I believe that I may say, especially since the Council on Medical Education of the American Medical Association began to be a power in the advancement of medical education, has the clinical chair of mental diseases become more than an ornamental appendage to some other chair and is now coming into its own as a factor in real education—education for a purpose. Many medical schools, I have learned since I have become interested in the work of medical education, have to be driven into line, and even then, like the horse, "we may lead him to the trough but we cannot make him drink."

It is a pleasure, a real intellectual treat, to see now and then in the medical schools in smaller medical centers, like Indianapolis and Ann Arbor, a roster of clinical lectures on mental diseases held in the hospital owned by the state, equipped especially for clinical instruction by the state, and contributed by the state as their part in the endeavor to disseminate knowledge of mental diseases among medical men. To me this is a wonderful advancement, a true triumph for scientific medicine and second in importance for the public welfare, to the establishment by the state of hospitals for the housing of the insane.

This is the second period of advancement, the clinical period, so styled by Janet; but in this part of the country it is belated. Illinois, alas! is just on the edge of the clinical period; it would have stepped into it this past year but for the fact that we as a state, as reflected in the minds of our legislative body, are still in the nursing bottle stage of this great educational problem. We need to progress; we need to study the history of civilization; we need to read White's Warfare of Science with Superstition and have more genuine love for science and trust in its establishing truths. We must have our sister states Indiana, Michigan, show us how they educated their people to believe in clinical instruction in mental diseases and to profit by it.

I am afraid Illinois comes under the criticism applied to medical education in the United States, which I recently read in the London Lancet, as follows: "This position of affairs (speaking of regularity of requirements) had its origin in the evolution of the United States, certain divisions of the country being in the forefront of civilization while others were, to say the least, in a rudimentary plight." Illinois is in a rudimentary plight just now, but the people, as I before said, I believe stand ready and willing to follow in every advancement for the educational betterment of themselves and of the medical profession. Illinois has, however, in so far as improving the service in state hospitals, in insuring a more stable and developed medical service, made great advancement in the past two years; first in inaugurating Civil Service for the medical staff, which I am sure will secure efficiency after it gets to working in normal channels.

Again, it has made provision for the educational advancement of this permanent medical staff by establishing the Psychopathic Hospital at Kankakee, where facilities for thorough clinical instruction in all that pertains to mental diseases will be undertaken. This, too, will require time to develop in its full potential possibilities for genuine wholesome work. From this much desired nucleus in our state is to go out the great work of education, which will directly affect the problems encountered in hospital practice and, indirectly, the whole medical profession; for with thoroughly trained clinicians in the state-service, they will and should, reflect their knowledge upon the mass of the profession through the channels of the

medical societies; the current literature, general and special, of the profession; also, through popular lectures before local lay societies, the woman's club, the literary and philanthropic organizations and through the magazines and other popular current literature. Surely, the field is great but the harvesters are few, and speed the day when the medical profession and the layman may be informed regarding the real worthwhile knowledge of insanity. The duties of the physician interested in mental diseases are arduous and confining and largely so because of the vast amount of education which he is required to impart, not only to the patients for their own guidance, but to the familes and friends of the patient. I remark to my nurses that in order to treat the individual we must treat his whole family, because without their co-operation our efforts would be futile.

This suggests the thought of what preparation really is required for the special work of care and treatment of mental diseases and that field the Psychopathic Institute is to occupy in educational lines. In a great measure the clinician must, through choice and not chance, select the work before him. This suggests, too, that the earlier such selection is made in his preparation the better for the clinician and the better for the work which he is to do. He should have the best possible preliminary training, preferably a biological collegiate course, with mathematics thrown in as a valuable side line; then, a good up-to-date medical college course, in which, again, his biological training, in his laboratory studies, will be of great service.

A hospital course in a general hospital and, preferably, a teaching hospital where clinical instruction is given to students; then service in the state hospitals. In the special training in the psychopathic hospital he should have psychology (normal and abnormal), which should include sociology; psycho-physics or applied psychology in order to elucidate mental phenomena; then a training in genuine true optimistic philosophy which will give him equanimity, power of self-control and cultivate hope, cherish ideals, all of which adds to that wonderful therapeutic power found in psycho-therapy. I add this last because my observation teaches me that the successful physician in mental diseases must know characteristics; must know personalities, and must reflect hope, cultivate hope and stimualte hope at all times and under all conditions. He then should direct the reading of his patients and their friends so that they may live in the educational atmosphere which cultivates their own powers of self-control and reflects them upon others with whom they come in contact. You know that we are creatures of habit, and, too, we follow, consciously or unconsciously, examples, especially environmental examples which lead to the formation of habits, good, bad or indifferent.

To properly radiate good habits, environmental conditions must therefore be good, and to know truly within ourselves what are the best conditions conducive to a long life of happiness, we must familiarize ourselves with the teachings of such leaders in mental hygiene and practical every-day psychological progress as those of Weir Mitchell, Stanley Hall, Clouston, Forel, Du Bois, Mercier and others, who have in the recent literature of today pointed ways of living which, even in the nervous, are compatible with a useful and happy life. Again, "Don't Worry Don't," while largely fictional and looked upon as a joke, are helpful in the line of suggestion to those who will but heed them.

Environment is a powerful determining influence, perhaps not as great as shown in the hereditary transmission of species, but even Weismann in his work on Evolution regards it as a power, and as the influence in the production of functional disturbances of mind; it is, in my judgment and experience, the most debilitating and productive factor we have to meet. This suggests one of the most prominent duties of the medical man, aye! paramount in its ultimate good, prevention, by educating the people into the knowledge of the facts of insanity, which will be of service to them in prevention of insanity; to teach them the earliest manifestations, which are largely nutritional disorders, and which, if early recognized, can be met, but which, if allowed to go on, do insidiously lead to the profound and distressing mental disorders. Mercier say, "such facts of insanity must be of service, for this malady more than any other it is true that the earlier its beginnings are recognized the better the chance of prevention and the more sanguine the hope of cure."

Time will not permit me to discuss with you these facts, nor to go further in discussing ways and means of disseminating them among the people, but I will say that upon the education of the masses depends not only the prevention of disease, which is a crowning glory of the past and of this century in medicine, but from the standpoint of the ultimate and final problem, which Huxley says, to which all great sociological problems finally resolve themselves, viz., the financial side, I would say that in dollars and cents (the avenues with which we can only hope to reach that great majority of mankind) it means money saved to provide psychopathic

hospitals; it means money saved to educate your physicians to the highest possible attainments.

I can not refrain in closing to say that my own profession, thank God! in its ideals, looks for a greater reward to the state, to the people, to the profession of medicine, and that is in having a faithful service crowned with the ultimate purpose of true medical science, in the prevention of disease, in the cure of disease and of adding peace and comfort to mankind.

THE Secretary of War has lessened the requirements for admission of medical officers of the National Guard to the Army Medical School. Henceforth no physical or mental examination will be exacted, a certificate from the Governor vouching for the qualifications and character of the applicant answering the purpose.

CIGARETTES IN THE NAVY.—In his annual report, Surgeon-General of the Navy, Presley M. Rixey, recommneds that an order be issued by the Navy Department forbidding the use of cigarettes by all persons in the navy under twenty-one years of age. It is stated that in three months the crews of the battleship Missouri (700 men) used 1,500 books of cigarette papers., 1,200 pounds of smoking tobacco, and 37,000 cigarettes. None the less, 8,000 cigarettes and 15,000 pounds of candy, together with 1,000 pounds of navy plug chewing tobacco and 30,000 cigars, have been loaded on the Culgoa in the Brooklyn Navy Yard as a part of the canteen supply.

REFORM IN CHINA.—On the 15th of the eighth moon there was a burning of opium pipes on the city hill of this city. Several months ago public-spirited citizens formed two societies to aid in suppressing opium smoking. They offered to buy pipes if given up before the seventh moon; offered medicine and services of physicians to those breaking off the habit; opened an industrial school to teach trades to waiters in opium dens; offered to lend four dollars to those who wanted capital for trade. Well, a large number of pipes and other utensils used in smoking were brought in and redeemed, so a day was set for the public burning of these trophies of reform, and a large crowd assembled to witnses the sight. First an address was made to the assembly, then a piece of music was performed on an organ, then the fire was applied to the pile of five thousand opium pipes and other utensils, and the services were closed with another address.—Hangchow correspondent of the Shanghai Mercury.

THE MEDICAL FORTNIGHTLY

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EDITORIAL

Lafayette Hospital.

ASSOCIATED with New York we doubt if there is a physician who would for a moment be in doubt as to what was meant when "Bellevue" is spoken of; naturally Bellevue Hospital is referred to; but how many St. Louis physicians know where or what Lafayette Hospital is? We ran across a surprising bit of information recently in connection with an examination of patrolmen conducted by the Board of Police Commissioners; it was this: the institution which we laboriously refer to as "the City Hospital" is, by rights, Lafayette Hospial. We doubt if there are many physicians in the city who are aware of the fact, and we presume a majority of the probationary policemen fall down on its location. We have down on Lafayette Avenue a wonderful institution, a hospital which compares favorably with the most noted in the country; its equipment is excellent, its service is of the best, and it is being ably managed. How many physicians know what is being done at "Lafayette Hospital?" A vast majority are as ignorant of the equipment and work of this institution as we were of the name which we find associated with it. We go to New York, to Boston, to Chicago, to any other city and spend our time in admiration of institutions which offer inferior service and advantages to the student to what is on tap in our own bailiwick, and we think we are well repaid for the time and money spent when better is at hand and ours for taking advantage of it! Whether it is called Lafayette Hospital or the City Hospital, it is an institution of which St. Louis, and the St. Louis profession may well be proud. We believe the health authorities of the city and the staff of the hospital would do well to entertain the St. Louis Medical Society some convenient evening and introduce the majority to the superb buildings

and the work being done in them; at present very few others than those connected with the faculties of the schools and the small group of chance friends have any appreciation of the ability of this institution to stand any sort of inspection, or the cordial welcome which awaits those physicians who may interest themselves in it. There is always good work to be seen at the City Hospital, and why not make use of it?

Rockefeller Institute.

THE establishment of institutes for medical research is a comparatively recent innovation in America, and one to the worth of which the profession is fully alive. We know of no way in which money may be invested with a greater certainty of its investment resulting in the betterment of the human race. The endowment of colleges, the founding of libraries, the establishment of charity and hero funds are all good, but each pales into insignificance beside work which has for its aim the elimination of suffering, the warding off of death, which shall enable men to work and care for those dependent on them. The accomplishment of modern medicine along the lines of preventive medicine have taken tremendous strides during recent years and it seems we are approaching closely to even greater discoveries. Tuberculosis, cancer, syphilis and numerous other dread diseases we may see under control in our day, if we do it will be through the work of research institutes, such was that founded through the munificence of Rockefeller. The recent announcement that Mr. Rockefeller has added a large sum of money to the endowment fund of this institution should be a matter of congratulation and appreciation to the entire American profession. In a work like this we have no time to talk about "tainted money," nor inclination to do so.

The medical profession is less idealistic than our brothers of the church, we have to make the best of conditions as they are, and we learn to see good in almost everything. And seeing good we hope for better things.

The Annual Election.

THE St. Louis Medical Society is in the throes of its annual upheaval—its annual election. The inauguration of a new organic law with new provisions for the conduct of elections and a clean slate, necessitating the election of a considerable number of men, marks this as an exceptionally trying experience for the individual voter and for those who have the supervision of the election. Happily there is such a general cordiality existing at present, and such general confidence in the sincerity of all concerned that there seems to be little chance of any but harmonious action. The new law provides for two ballots, the first being a nominating ballot, and the second for election; with blank nomination ballot before him the average member finds himself at a loss where to begin and for whom to vote, there has been so little campaigning that there is little to go on. To insure some unanimity of action those active in the affairs of the society secured from a number of men well versed in its affairs a series of suggestion ballots which seem to include the most effective of the available timber. These, with an explanation of the why of their appearance, are being placed at the disposal of the membership, and, while it is too early to state how effective they may be, it is believed that they will be received in the spirit which prompted them and will not be looked upon as in any sense campaign documents, or in any sense partisan in their aim. The situation is unusual; it will never again be quite so difficult, and it is hoped that every voter will exercise himself to place in each office for the coming year the most efficient man available.

The Medical Brief.

WITH its December issue the Medical Brief for its last time appears under the ownership and editorial management of Dr. J. J. Lawrence, who is now retiring from all commercial and other connection, and will spend his declining years as a spectator of those activities in which he has so long played an important part. Dr. Lawrence made the Brief an organ for the country physician; during its palmy days it played to its audience rather than above their heads; this was the chief reason for its popularity, and the chief occasion for the criticism that it was failing to work for the educational elevation of the profession. During later years the Brief has felt the swing of the pendulum, and its original department has been above reproach; in fact the contributors have been men whose contributions were sought by the most highly scientific journals of the country. Dr. Lawrence has always been a man of strong convictions and possessed the sturdy manhood to defend them even when they ran counter to "policy." He has been an important factor in American Medicine. Friend and opponent will unite in wishing him a serene old age,

for in his active years he has been a staunch friend and a fair opponent, and we respect him for his fearlessness and for his unquestioned integrity.

The Brief has a future which promises to be an important factor in things medical. Mr. Strong, who will control its future, is a man most favorably known to the pharmaceutical world, through his "National Druggist," and not unacquainted with medical conditions and needs. His purpose is to make the Brief a journal more than ever helpful to the general practitioner; his aims are that it shalll be scientific, independent and fearless. Rumor has it that the editor who is to direct its scientific energy is a man not unknown to our readers and a man of undoubted ability and integrity; be this as it may, we wish the Brief all manner of good things in its future; may it act fearlessly for the elevation of our calling, as we believe it will.

LOCAL MEDICAL NEWS

The Barnes Hospital.—St. Louis is soon to have a new hospital built according to the most approved ideas in hospital construction. The site chosen is the ground between King's Highway Boulevard and Euclid Avenue opposite Forest Park. The board of trustees and the architect have spared no pains to gather information at first hand from the leading hospitals both in this country and abroad. Preliminary plans have already been submitted and as soon as the details are worked out it is expected that the work will be pushed as rapidly as possible.

Dr. George Herbert Sheldon died at his home in this city on Monday, November 25th, after a long and trying invalidism due to an organic heart lesion. Dr. Sheldon had known of his heart trouble for some years, but in spite of this knowledge and in the face of advice against it he persisted in aquatic sports, his last notable achievement in this line having been the winning of the high diving trophy in the International contest at the World's Fair. He has never been well since that summer. He leaves a greatly bereaved mother; to her we would express our profound sympathy.

The officers of the St. Louis Medical Society gave a smoker to the membership on the evening of November 30th, which was one of the most notable events of the kind ever enjoyed by the local profession. The occasion was primarily social, and in that it eclipsed the fondest hopes of its promoters. The spirit of good-fellowship pervaded the atmosphere and everybody was in a most cordial humor. This spirit showed itself in the addresses of the speakers of the evening, Drs. H. Tuholske, R. M. Funkhouser, C. H. Hughes, Edward Borck and J. M. Scott. Dr. Frances Bishop and her associates served a most delectable lunch. We understand that the last Saturday in months having five Saturdays is hereafter to be devoted by the society to some such social occasion. The precedent is splendidly established in its inauguration.

Our Society Auditorium.—No city is better off in the matter of medical headquarters than is our own; we are only beginning to appreciate this fact. The construction of a more ornamental entrance and the building of ante-rooms are now well under way, and on their completion there will be nothing left to desire in so far as our present needs are concerned. Our Cincinnati neighbors seem to feel that they are pioneers in the matter,; we regret that they have a less handsome and convenient home than we, for we are not at all selfish in our possession.

Death of Dr. A. M. Carpenter.—The death of Dr. A. M. Carpenter removes another of the older physicians of our city. Dr. Carpenter's death occurred at the Centenary Hospital on December 3d, and ended an extended illness. He came to this city some twenty-five years ago, from Keokuk, where he had been dean of the Keokuk Medical College. In this city he was continuously active in matters of medical education, being in turn professor in the P. and S., the Marion-Sims and the Barnes. He had never identified himself strongly with organized medicine, but was an influence which was strongly felt in such organization. His death is a matter of definite regret to the St. Louis profession.

The National Medical Association recently assembled in seventh annual meeting at Baltimore. This guild is for colored physicians exclusively, about three hundred of whom listened to the deliberations.

Physical Training in Italy.—A National Institute for Promotion of Physical Training has been organized at Rome, and its first work was to appoint committees in every province, with subcommittes, all working for the same end. In order to co-ordinate effort it has been decided to hold a general reunion of representatives of the committees and subcommittees at home next April, where ways and means will be discussed and organized effort decided.

THE REVIEWER'S TABLE

Books, Reprints, and Instruments for this department, should be sent to the Managing Editor, Century Building, St. Louis

FIVE HUNDRED SURGICAL SUGGESTIONS. Practical Brevities in Surgical Diagnosis and Treatment. By Walter M. Brickner, B.S., M.D., Chief of Surgical Department, Mount Sinai Hospital Dispensary; Editor-in-Chief, American Journal of Surgery, and Eli Moschcowitz, A. B., M. D., Assistant Physician, Mount Sinai Hospital Dispensary, New York; Associate Editor, American Joural of Surgery. Second series. Pages 125. New York: Surgery Publishing Co., 92 William street, 1907. (Price, $1.00.)

It is not surprising that the first edition of "Surgical Suggestions" was quickly exhausted. The attractive little volume was most favorably received by reviewers, and its contents—the snappy, practical "suggestions"—have been reprinted again and again by medical journals all over the country.

In this second series all the surgical suggestions of the first issue have been incorporated, and as many more, making a total of five hundred terse, useful "therapeutic hints and diagnostic wrinkles." Several new topics have been thus introduced and the old ones much expanded. An index is provided. The paragraphs, as before, have all been suggested by the authors' own observations. Many of them are bits of wisdom that are not to be found in the text-books. We do not believe that even an experienced surgeon will fail to find among these five hundred suggestions some hints that will repay him many fold for the leisure hour spent in reading this small manual. And to those who have not enjoyed many years of active surgical work, five hundred practical, epigrammatic surgical dicta will surely prove immensely helpful. The internist is concerned in the diagnosis of surgical and borderline affections, and to him, also, we commend the many diagnostic hints between the covers of this little book.

As before, the publication has been prepared in a manner worthy of its unique contents. It is a pocket manual de luxe!—printed in attractive Cheltenham type, on antique India tint paper, with marginal headings and subheads in contrasting ink, and with an artistic binding of heavy cloth, gold-lettered.

PROGRESSIVE MEDICINE, Vol. II, 1907. A Quarterly Digest of Advances, Discoveries and Improvements in Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, 381 pages, with illustrations. Philadelphia and New York: Lea Brothers & Co., Publishers. (Per annum, in four cloth-bound volumes, $9.00; in paper binding, $6.00: carriage paid to any address.)

This issue of Progressive Medicine (Volume II of the 1907 series), reviews many vitally important subjects, and embraces a wide range of interest. It opens with a thorough resume of Hernia, by Dr. William B. B. Coley. The information therein is of value to every surgeon. Under the radical cure of femoral hernia many methods are discussed on their relative merits, hundreds of cases are summarized, and the after-results clearly stated. The best methods of procedure are freely illustrated. So also with inguinal hernia in children, umbilical hernia, cryptorchism, hernia through the foramen of Winslow, etc.

On Surgery of the Abdomen, exclusive of the foreging, Dr. Edward M. Foote reviews the early diagnosis of abdominal hemorrhage, the value of the blood count in sepsis (based on a sudy of 2,000 surgical cases), diffuse suppurative peritonitis, post-operative thrombosis, the omentum and its functions, displaced organs, etc. In answering the question: "When does Gastric Ulcer become Surgical?" he writes:

"Practically then ulcers are of two classes. Those that appear in young and generally anemic women, yield to rational medical treatment in about 80 per cent of the cases. The remaining 20 per cent of medical failures are turned over to the surgeon as the last resort, and he is able to cure about one-half of these."

The pages dealing with the mechanism of subcutaneous rupture of the intestine, the results of operation for acute intestinal obstruction, the early symptoms of appendicitis, and Pilcher's method for the treatment of hemorrhoids are of especial interest. Many of these subjects are freely illustrated. Diseases of the liver, pancreas and spleen are reviewed wih equal care.

Under Gynecology Dr. John G. Clark urges the profession at large to watch with the minutest care the earliest symptoms of cancer of the uterus. After mentioning the present crusade against this dread disease and its increase and cause, as indicated by many investigators, he writes:

"While it is to be regretted that there are no early pathognomonic signs, this very deficiency should put every physician on his guard and cause him to investigate the comparatively meagre symptoms present in many cases.

Dr Clark then details five suggestive signs which, if followed as axioms by the general practitioner, would tend very materially to reduce the mortality from cancer. The results of the operative treament for cancer of the uterus, other methods of treatment, fibroid tumors, enteroptosis, metrorrhagia, myopathica, the disorders of menstruation and the non-operative methods of treatment of gynecological diseases are some of the other matters discussed.

Dr. Alfred Stengel devotes eighty-six pages to all that is new and of practical value in recent literature dealing with diseases of the blood, diathetic and metabolic diseases, and

diseases of the spleen, thyroid gland and lymphatic system. The reader is at once struck with the wealth of sources consulted, the range of knowledge involved, and the scholarly clearness with which they are grouped. Especial attention is given to the treatment of the various forms of disease, as well as the stains and methods for examining blood.

THE PRACTITIONERS' VISITING LIST for 1908. An invaluable pocket-sized book containing memoranda and data important for every physician, and ruled blanks for recording every detail of practice. The Weekly, Monthly and 30-Patient Perpetual contain 32 pages of data and 160 pages of classified blanks The 60-Patient Perpetual consists of 256 pages of blanks alone. Each in one wallet-shaped book, bound in flexible leatner, with flap and pocket, pencil and rubber, and calendar for two years. Price by mail, postpaid, to any address, $1.25. Thumb-letter index, 25 cents extra. Descriptive circular showing the several styles sent on request. Lea brothers & Co., Publishers, Philadelphia and New York.

Being in its twenty-second year of issue, The Practitioners' Visiting List embodies the results of long experience and study devoted to its development and perfection

It is issued in four styles to meet the requirements of every practitioner: "Weekly," dated for thirty patients; "Monthly," undated, for 120 patients per month; "Perpetual," undated, for 30 patients weekly per year and "60 patients," undated, for 60 patients weekly per year.

The text portion of The Practitioners' Visiting List for 1908 has been thoroughly revised and brought up to date. It contains among other valuable information a scheme of dentition; tables of weights and measures and comparative scales; instructions for examining the urine; diagnosis table of eruptive fevers; incompatibles, poisons and antidotes, directions for effecting artificial respiration, extensive table doses; an alphabetical table of diseases and their remedies, and directions for ligation of arteries. The record portion contains ruled blanks of various kinds adapted for noting all details of practice and professional business.

Printed on fine, tough paper suitable for either pen or pencil and bound with the utmost strength in handsome grained leather, The Practitioners' Visiting List is sold at the lowest price compatible with perfection in every detail.

THE annual report of the Cincinnati Hospital shows that, for the year 1906, the total number of patients treated at that institution was 7,878, the largest number of patients in the hospital at one time being 592, the smallest 380, the average number of patients 477. The gross cost of each patient per day was $1.05; the total expenditure for the year was $183,676.00. Of his amount only $4,285 were received from pay patients.

MEDICAL PROGRESS

Comprising the Regular Contributions of the Fortnightly Department Staff.

OTOLOGY.

A. E. KOETTER, M. D.

The Influence of Fatigue on the Hearing.—Rugani and Fragola (Arch. Ital. di Otologia) made their examinations on cavalrymen and infantrymen. The manner of fatigue varied, bicycle riding, running, military exercises, riding, endurance walking. Men of long and recent service were used. The hearing was tested shortly before and after the fatiguing exercise, and sometimes after many hours. As a general rule individuals with normals ears and nerves were tested. The tests included the following: Condition of membrane; bone conduction—a, with watch, b, with tuning fork (Weber, Schwabach, Rinné); air conduction (watch); different tuning forks (Gradenigo's scale); whispered voice (Ostino); nystagmus; equilibrium test. It was found after every exertion, an equal bilateral decrease in the hearing. The amount of loss is in direct proportion to the amount of exertion. In those indiviuals accustomed to exertion the decrease is slight. In all cases the normal hearing returned after some time. In individuals with diseased ears the decrease in hearing is very marked. The membrane is more or less congested in nearly all cases. All these phenomena are dependent on the vasomotor disturbances and the fatigue intoxication.

The Breathing and Pulsating Movements of the Drum Membrane.—Zitowitsch, St. Petersburg, examined 116 individuals (232 membranes), of these 27 were normal, 16 with tubal catarrh and 12 with otosclerosis. For the examination he used a manometer of Politzer with some changes made by himself. As ear obturator he used an air-tight rubber stopper through which the glass tube passed. For reading the pressure fluctuations in the external canal he used a drop of colored fluid in a graduated tube. Both ears were examined at the same time with the manometer. The results are as follows: 1. The membrane can move outward as well as inward in inspiration (3:1). The amplitude of the movements is about 1 mm. In acute and exacerbated catarrhs of the nasopharynx the movements may cease entirely. 2. The cause of the movements are as follows: (a) The pressing of the air from the tube to the middle ear (contraction of the muscles of the tube). (b) The whirlwind movements of the air in the ostium tubae which favors entrance of air into tympanic

cavity. (c), The difference in pressure in the tube and in the nasopharynx. (d) The aspiration of the air from the tube respectively from middle ear in deep breathing. 3. In inspiration the ostium tubae becomes narrow in expiration wider. 4. In mouth breathing no manometer fluctuations are observed. 5. The drum pulsate isochronous with the pulse.

The Differential Diagnostic Meaning of Sonder's Blood Count in a Case of Acute Brain Abscess and a Case of Acute Mastoiditis.—(WP.. Brandegee, Annals of Otology).—In the first case the number of polynuclear cells rose parallel to the increase of the symptoms and fell off after the operation and evacuation of the abscess. In the second case the number of polynuclear cells suddenly decreaed from 77% to 65.9% wihout any diminution in the symptoms of the patient, a boy of twevle. Author intended operating, but desisted when number of polynuclear cells decreased, and in two days improvement occurred.

Deafness in the Course of Acute Osteomyelitis and from Septic Processes in General.—(Siebermann, Zeitschrift fuer Ohrenheilkunde.)—In the literature four cases of deafness following acute osteomyelitis are known. Author reports three further cases observed by him. On the basis of these clinical histories, which show many similar features, Siebermann develops a clinical picture of osteomyelitis deafness. In all severe cases an acute bone disease, accompanied by high fever, was present. Deafness always bilateral. The course of the deafness usually very rapid. In the three cases of author deafness occurred within a few hours respiration, days for the voice. A test of the static function in author's patients showed that the static sense coincided with that of the acoustic. As to the nature and the anatomical seat of the process producing deafness everything points to disease of the internal ear. To clear the pathologic-anatomical relation further post-mortem (only one known at present—Steisbrüge) must be awaited. After thorough discussion of septic bilateral deafness in general and analogous septic diseases of the eye, the author reaches the conclusion that the osteomyelitic deafness is very likely an inflammation, not of the nerve, but of the labyrinth. One of the cases of Siebermann which was also examined bacteriologically showed the presence of pure staphylococcus infection. In conclusion, Siebermann points out the fact that evidently the same damaging role which the streptococcus plays in septic ophthalmia is taken by the staphylococcus towards the labyrinth.

Traumatic Disease of the Internal Ear.—(Th. I. Harris, Annals of Otology.)—Woman of 50, suffering with panotitis of eighteen months. There existed severe deafness, vertigo, tinnitus and sensation of fulness in occiput. After discovery and treatment of empyema of accessory cavities of the nose, improvement was manifest in every respect. Six months after beginning of treatment author used mild vibratory massage of the left side of head. Vertigo returned in more violent manner and remained for several weeks. Three months later a few drops of a 1:5000 adrenalin solution were instilled into left ear. Severe pain immediately, vertigo returned, ear began to secrete and became totally deaf. Author believes a defect of the labyrinthian wall of tympanic cavity caused adrenalin to enter directly into internal ear.

Results on the Use of Alypin in Otology.—Bürkner (Berliner Klinische Wochenschrift) recommends alypin in 5 to 10% solution in place of cocain. Even in paracentesis Bürkner's effective anesthesia was secured with 5% solution, but only then when epidermis layer was not intact. Subcutaneous injections of alypin, suprarenin in extraction of ossicles were successful.

SURGERY.

Glycosuria in Its Surgical Relations.—Dr. A. E. Halstead, Chicago (Jour. A. M. A., Sept. 7), discussed the relation between traumatism and certain surgical diseases and sugar in the urine. After noticing the work of Redard, Hadke and Kausch in this line, he reports his own observations. He has examined in this regard 50 cases of fracture, 6 of them fractures of the vertebra. In 3 of the latter sugar was found; in 2 directly after the injury, one patient dying on the second and the other on the third day. The third glycosuric patient died on the twelfth day; all th enon-glycosuric patients lived over two weeks. Of the remaining 44 patients, all of whom had simple fractures—6 had sugar in the urine for periods of 12 or 14 days; in none were there other signs of disturbed sugar metabolism or was the healing of the fracture influenced. The chief significance of these observations, in his opinion, is in their pointing to shock or cerebrospinal concussion as the principal cause of the condition. Such ephemeral glycosuria does not seem to have any influence on the healing of the injury. Nevertheless, he would postpone operations that are not imperative until the disappearance of the sugar. A more permanent glycosuria might possibly result from the shock of operation or the anesthesia, and

the chances of non-union be greatly increased. The secondary transitory glycosuria due to drugs or infections do not seem to affect the prognosis of surgical infections greatly, but, according to Halstead, it should cause the postponement of major surgery while the needed measures for its relief are being carried out. It is not a contraindication, however, to necessary minor surgical procedures, but rather the reverse. In long-continued suppuration the possibility of a secondary glycosuria becoming permanent must be kept in mind. In erysipelas, sugar in the urine is of serious prognostic moment, as an index of the severity of the infection. In diabetes, imperative operations have to be risked, and, from his review of the evidence. Halstead does not think that we can always take the quantity of sugar excreted as a guide to the safety of an operation. Other subtsances, acetone diacetic acid, etc., indicate a greater danger of coma than any quantity of sugar alone. He would try a thorough course of treatment in case a high pecentage of sugar is present, before performing any operation that can be postponed. Under aseptic conditions, except in the lower extremities where the circulation is likely to be impaired, wounds heal readily in diabetes. The dangers incident to infection, however, are increased and operations that are avoidable should not be considered. Too much stress can not be laid on the importance of a rigid course of preliminary medical treatment. Inhalation anesthesia, even by nitrous oxid, should be avoided so far as possible. In case operation is unavoidable ether is the least, and chloroform the most harmful. Local or regional anesthesia should be the form employed whenever possible. Halstead insists on the importance of prophylaxis as regards gangrene in diabetes. The danger of infection of even insignificant abrasions should be impressed on the patient, and corns, warts and calluses of the lower extremities should receive careful attention and should be treated only under the most rigid antiseptic precautions. When gangrene has occurred the question when and where to operate is of importance, and the condition of the arteries will have to be considered. When the gangrene has reached the dorsum of the foot, obstruction of the popliteal at its bifurcation has possibly occurred and amputation above the knee is always to be advised. A general anesthetic is unnecessary in most cases as spinal cocainization will generally suffice.

Intestinal Obstruction.—Dr. R.D. McClure, Baltimore (J. A. M. A., Sept. 21), gives a detailed account of experiments undertaken to answer the question as to the cause of the symptoms (vomiting, collapse, disturbances of blood pressure, sweating, etc.) following occlusion, whether they are reflexes from nervous irritation or are due to the absorption of poisons from the obstructed intestine. His methods were along lines similar to those of previous experimenters (Kukula, Albeick and others) and consisted in introducing some of the contents of an obstructed intestinal loop of a dog that presented the above symptoms into the isolated loop or the peritoneal cavit of another dog. When this was done into the pertoneal cavity the symptoms appeared, but the animal soon recovered, but when the intestinal contents was introduced not a loop entirely isolated, the continuityof the gut having been re-established byanastomosis, death always occurred in a few days with symptoms like those of obstruction. In all instances the isolated loop became greately distended and contained great numbers of bacteria as in ordinary obstruction. It evidently acts like a culture tube, and it would seem that the symptoms and death were due to the absorption of toxins from the bacteria. Still, not all the experiments were free from objection, as in several, the mesentery became twisted, interfering with the vitality of the loop, and in one or two ulceration and perforation occurred. Excluding, however, conditions of ulceration leading to peritonitis or those in which infarction renders the walls permeable to bacteria, it seems that obstruction may persist for days with enormous distension of the gut and growth of bacteria. The bacterial poisons alone may be absorbed while the germs themselves do not leave the intestinal lumen. It seems probable that this may also occur in man, though there may be a later invasion of the issues by bacteria with septicemia. In animals the symptoms are such that it is difficult to see how irritation of the intestinal nerves can be their cause, and it seems just as reasonable to assume that in many the symptoms of obstruction are rather the result of intoxication than of any mechanical disturbance of the nervous mechanism of the intestinal wall.

In its last monthly bulletin the New York State Board of Health makes the following statement in regard to cancer: The cancer problem is assuming more and more menacing proportions, there being reported 572 deaths, from this cause in September, 1907, as against 526 in the same month last year and an average for five years of 456. Thus, while deaths from tuberculosis are held practically stationary, we are doing nothing to hold cancer in check as a cause of mortality.

SOCIETY PROCEEDINGS

MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

Thirty-third Annual Meeting, held at Columbus, O., October 8-10, 1907.

(Continued from page 555.)

MEDICAL SECTION.

Influence of Medical Men on Human Progress.

DR. GEORGE F. BUTLER, Chicago, in the address on medicine, said that if we are to prevent disease as our chief mission, or as the most effective method of warfare on this enemy of human progress, the conditions must be known, not merely the material, mechanical and social from which they result, but the primary conditions that lie still farther back of the immediate conditions that result in diseases. He discussed the relations between the physicians and the public service, and gave considerable attention to that need for a better understanding of the social question and deplored the danger to innocents of silence and secrecy. He advocated the abolition of state lines with reference to medical practice regulations. Referring to expert witnesses in legal cases, he condemned "expert liars" in strong language. In the medical profession, as in religion or science, the perils of dominating influence can not be escaped. Material things may be taken in charge of by trusts, but truth should never be syndicated. No man nor set of men have any right to restrict a physician in the use of any medical or surgical appliance which he believes may cure or prevent disease, nor to prevent him from reading any text-book or medical journal which he may regard as helpful to him in acquiring knowledge that may assist him in the practice of his profession. All the various schools of medicine are gradually coming together and joining hands in the efforts to cure and prevent the ills of mankind. Physicians should be permitted to practice medicine under national laws. Medical men have always been connected with the march of human progress, and many of them have made admirable statesmen. The medical art always has either directly or indirectly, stimulated every other art and science.

The Relation Between the Medical Profession and the People.

PRESIDENT H. H. GRANT said that we all realize that the world is full of wretchedness, deformity and disease; that this is due to ignorance and cupidity, distributed well over the whole population from rich to poor. We all realize the measures of relief must be a slow and gradual reform, conducted by a concentration of many influences, wielded by society at large. We all realize the obstacles to success, as well as the possibilities of abuse in the methods, and we all know the need of a directing influence which is thoroughly informed and can be confidently entrusted with power. It is his belief that through the trust and the support of the general public, given to a conscientious medical profession, disinterested as a body, with identical concerns with the public, a highly comforting progress will be soon recorded. With a view to the hopeful advance of these noble and world rewarding benefactions, let the profession of medicine, without jealousy or thought of self-interest, devote its wisest and most faithful workers as chieftains; let the lay and the religious press, ever ready on conviction as earnest and determined associates, with unremitting zeal, uphold and champion the cause, and add to this the patient and neverfailing confidence of a liberal and trusting general public rallying its invincible support, and there shall open up before the coming generation such a prospect of achievement and victory as will be a soul-satisfying record.

Neurasthenia Gastrica.

DR. CLEMENT R. JONES, Pittsburg, reported four cases and concluded that neurasthenia gastrica or nervous dyspepsia is frequently due to or complicated by eye-strain. Other gastric disturbances are sometimes aggravated by eye-strain. When eye-strain is the cause of gastric symptoms, the relief by proper refraction is prompt and satisfactory.

Reinfection with Syphilis.

DR. A. U. WILLIAMS, Hot Springs, Ark. (Paper appeared in full in issue of October 10).

Toxemia from the Standpoint of Perverted Metabolism.

DR. RALPH W. WEBSTER, Chicago, concluded that toxemia, said from that following the acute or chronic bacterial processes, is always of metabolic origin. The toxemias under discussion are more the effects of a general metabolic perversion than of a direct organic disorder. A specific toxemia, in the sense that it is due to a specific substance, is unknown in the class of toxemias treated.

DR. THOMAS HUNT STUCKY, Louisville, followed with a paper on autointoxications of intestinal origin resembling typhoid fever.

The Treatment of Scarlet Fever as a Streptococcus Disease.

Dr. J. E. Coleman, Canton, Ill., has treated this disease with carbolic acid, internally and externally, together with small doses of aconite the first few hours until fever is allayed. In all of the cases he has thus treated, the disease was materially shortened, the rash rapidly fading, and on the second day the fever was gone, and the throat symptoms were also relieved. When this treatment was used there was not any desquamation of the skin, nor any after-effects from the disease, such as nephritis, or discharge from the ear. He has successfully treated cases of scarlet fever by the application of the two remedies mentioned since the time of an epidemic of the disease, year after year, admitting that the results he has obtained may possibly have been due to the fact that the disease ran a benign course.

Relations of the Doctor to the Alcoholic Problem.

Dr. T. D. Crothers, Hartford, Conn. (Paper appeared in full in issue of Nov. 11).

The Recognition and Management of Acute Mastoiditis by the General Practitioner.

Dr. Leartus Connor, Detroit, drew the following conclusions: 1. Patients with acute mastoiditis should be regarded as seriously ill, placed in bed, given a brisk cathartic, and diaphoretic, and the diet limited to at least one-half. 2. If there be present tenderness of the mastoid, redness and bulging of the inner, upper and posterior external auditory canal, and adjacent membrana tympani, Wilde's internal incision should be promptly done. 3. Regular irrigation with water, as hot as can be endured, should precede and follow the incision, and dry heat follow during the intervals of irrigation. 4. An aseptic should be applied to the wound after each irrigation; a 50 per cent solution of argyol on a cotton-tipped probe is convenient and useful. 5. Thus managed, many cases of aute mastoiditis speedily recover. 6. If they grow worse steadily, the mastoid must be promptly opened, all diseased tissues removed, and the wound dressed aseptically. 7. A painful deaf ear merits quite as careful attention as a red painful eye or a painful stiff limb. Until this be accorded it physicians will continue to have crops of extensive distruction of mastoid bones, permanent loss of hearing, infection of lateral sinus, facial paralysis, subdural, cerebral and cerebellar abscess and death.

Morphin Addiction.

Dr. George P. Sprague, Lexington, discussed some of the essential points in the etiology, pathology and treatment of morphin addiction. He divided the cases into three groups: 1. A small one composed of normal individuals, who, from unwise treatment for pain in acute illness, have contracted the habit. A second larger group of moral degenerates who indulge in the vice of morphinism, and a third, and much the largest group, recruited from among the neuropathic weaklings, from the victims of improper training and lack of early discipline; from the vast army of defectives, who beginning to lose ground in the race of life, resort to drugs as a spur, and from the large number, who, suffering from sudden shock of disease, loss, etc , resort to the drug in the hope of obtaining relief.

The patient should be under treatment for months; that he should not be alone a moment when he might procure morphin, day or night; that every one coming in contact with him must be above bribery, and that his nurse must be above suspicion, and ever suspicious. The patient's sense of right and power of will should be steadily stimulated, and every physical ill he may have should be found and vigorously combated.

The Nature of Morphin Disease.

Dr. Charles W. Carter, Richmond, Ind., said that the physician who would understandingly and conscientiously treat the morphin disease must have a generous breadth of view in reading human character, an entire want of prejudice in interpreting symptoms, and a broad and thorough knowledge of remedial agents.

Medical Inspection of Public Schools.

Dr. Frank W. Gavin, Canton, Ohio, said the medical inspection should look after: 1. The school building, its condition, ventilation, lighting, seating, etc. 2. The inspection of candidiates for teachers' certificates in the principles of preventive medicine and school hygiene. 3. Physical and mental condition of the child.

He pointed out the advantages of medical inspection and the methods of examination. He believes the salary of a medical inspector should be generous, thus warranting the selection of the best man procurable. He sincerely believes it would be money wisely invested on the part of cities and municipalities.

Urinary Infections in Children.

Dr. I. A. Abt, Chicago, pointed out the avenues through which microorganisms gain access to the bladder and to the pelvis of the kidney in these infections. Bacteria may

enter the bladder through the urethra, and migrate upward to the bladder and thence to the kidney. The infection may be hematogenous in character, the micro-organisms finding access into the bladder through the blood vessels. The microorganisms may pass in some manner from the bowel through the loose cellular tissue of the pelvis into the bladder. The fact that sometimes a bowel infection, particularly follicular enteritis, precedes an attack of cystopyelitis, has suggested this view. Congenital malformation of the bladder and kidneys predisposes to cystitis and pyelitis. Such a case has come under his observation. He described the symptoms and course of the disease.

As regards treatment, the ordinary urinary antiseptics in one form or another used internally will usually bring about the desired result. In the severe forms of streptococcus or staphlyococcus infection the vesical irrigation may be indicated. In other respects the treatment is purely expectant and symptomatic. The pain and restlessness may require the use of antispasmodics and sedatives.

On November 4, Dr. Carlos Finlay, chief of the Department of Health and Sanitation of Havana, was presented by Governor Magoon with the Mary Kingsley medal in recognition of his work in connection with the transmission of yellow fever by mosquitoes. The medal is awarded by the Liverpool School for the Study of Tropical Diseases to commemorate Miss Mary Kingsley, the African traveler.

A Bloody, Causeless, Victoryless Butchery.—There is no better illustration that the interests of the public are irrational and immoral than the utter disregard we have of the deaths and injuries from railway mismanagement. If a worthless man or woman is killed a whole community is excitedly interested in the affair, and the trial of the good-for-nothing murderer may cost a fortune, and absorb the attention of a nation.

If a bit of a quarrel with another nation results in a few hundred deaths, whole nations are frantic. And yet who cares or notices that last year 50,000 were killed in our railroad accidents," and 76,286 were injured? Who is shocked to learn that the killed this year are 775 more than last, and that about 10,000 more were injured? Doubtless some accidents are unavoidable, but just as certainly most are avoidable. But only on condition that we wish to avoid them! Few things more eloquently justify the cynical grins of the pessimists than the callous way in which modern luxury sacrifices life.—Am. Med.

The Medical Fortnightly

A Cosmopolitan Biweekly for the General Practitioner

The Medical Fortnightly is devoted to the progress of the Practice and Science of Medicine and Surgery. Its aim is to present topics of interest and importance to physicians, and to this end, in addition to a well-selected corps of Department Editors, it has secured correspondents in the leading medical centers of Europe and America. Contributions of a scientific nature, and original in character, solicited. News of Societies, and of interesting medical topics, cordially invited.

Advertising forms close on the first and fifteenth of each month. Time should be allowed to submit proof for correction Advertising rates on application.

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The Medical Fortnightly will not be discontinued at expiration of subscription, as many of our readers prefer not to have their files broken on account of failure to remit. Unless we receive a distinct request to discontinue, and payment for all arrearages, this magazine will not be discontinued.

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Soap Suppositories.—When glycerine suppositories are not obtainable, a cheap and efficient substitute is soap. A piece about the size of a man's thumb is made smooth, is wetted and pushed as far up the rectum as a finger will carry it. Loose, easy bowel-movement soon results. It is particularly applicable to young children who fight at every attempt to give an enema. American Journal of Clinical Medicine.

A Statue of the late Dr. Joseph Leidy, of Philadelphia, recognized as one of the most distinguished American scientists of the last cenury, was unveiled October 30, 1907, on the west plaza of City Hall. As president of the Academy of Natural Science, professor of human and comparative anatomy and zoology in the University of Pennsylvania and president of the Wagner Free Institute of Science, Dr. Leidy added immeasurably to the position these institutions hold in the world of science. He was born in Philadelphia in 1823 and died in 1891.